STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445174	A. BUILDING _____ B. WING _____	11/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKHAVEN MANOR	2036 STONEBROOK PLACE KINGSPORT, TN 37660

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An annual Recertification survey was completed on November 7-9, 2011 with an Extended survey completed on November 8, 2011. The facility failed to administer the facility in a manner to maintain the the safety of the residents by ensuring the fire sprinkler system was in a reliable operating condition. The facility was cited with an Immediate Jeopardy (situation in which a provider's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death). The Administrator was notified of the Immediate Jeopardy on November 7, 2011, at 4:00 p.m. in the Administrator's office. The Immediate Jeopardy for tags K-62, K-154, and F-490, at scope and severity levels of an "L", were effective from October 10, 2011, through November 8, 2011. On November 8, 2011, the facility provided an acceptable allegation of compliance lowering the Immediate Jeopardy. The scope and severity for K-62, K-154, and F-490, were lowered to an "F" level. Complaint investigation #28827 was completed during the annual recertification survey on November 7 - 9, 2011. No deficiencies were cited related to the complaint investigation #28827 under 42 CFR Part 483, Requirements for Long Term Care Facilities.	F 000		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of	F 221		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Christopher A. Gaddy | Administrator | 11/21/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 221	Continued From page 1 discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview the facility failed to ensure freedom from restraints for one resident (#14) of twenty-seven residents reviewed. The findings included: Resident #14 was admitted to the facility on July 20, 2010, with diagnoses including Fracture Femur, History of Falls, and Difficulty Walking. Medical record review of the Minimum Data Set (MDS) dated September 13, 2011, revealed the resident required extensive assistance with transfers, was not steady, and only able to stabilize with human assistance. Medical record review of a Physician's order dated November 7, 2011, revealed "...D/C (discontinue) soft belt waist belt...change to Lap buddy..." Observation on November 8, 2011, at 8:30 a.m., in the blue dining room, revealed the resident in a wheelchair with a soft waist restraint in place. Interview with Registered Nurse #1 on November 8, 2011, at 9:40 a.m., in the 400 Nurses' Station, confirmed the resident had a soft waist restraint in place, the order was for a lap buddy (not a restraint) and the resident had an unnecessary restraint in place.	F 221	**F 221** **Corrective action(s) accomplished for those residents found to have been affected:** Resident #14 on November 08, 2011: LPN received an order clarification to D\C soft waist and have lap buddy in wheelchair. **How other residents having the potential to be affected were identified and corrective action(s) accomplished:** Restorative Aid on November 15, 2011 checked all residents with restraint orders for correct restraint placement and type. **Measures or systematic changes put into place to ensure the deficient practice does not recur:** Beginning on November 7, 2011 and ongoing Licensed Nurses and Certified Nursing Assistants were educated by the Director of Nursing and/or Assistant Director of Nursing to ensure correct placement of a restraint on a resident. In service will be added to the employee orientation packet. **Quality Assurance program put into place to monitor corrective actions and ensure the deficient practice will not recur:** Beginning on November 15, 2011, the restorative aid or designee as determined by the Director of Nursing will do checks of restraints to ensure the correct restraint is in place two times a week for ninety days with monthly submission to the Quality Assurance Committee who will determine the need for future focus. The Director of Nursing or Assistant Director of Nursing will report findings in the Quality Assurance Committee meeting (made up of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Risk Manager, etc.)	11/21/2011

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F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview the facility failed to provide privacy during ADL (Activities of Daily Living) care for one resident (#16) of twenty-seven residents reviewed. The findings included: Resident #16 was admitted to the facility on April 8, 2011, with diagnoses including Hypertension, Encephalopathy, Dementia, and Chronic Obstructive Pulmonary Disease. Medical record review of the MDS (Minimum Data Set) dated September 25, 2011, revealed resident #16 was completely dependent on staff for all ADL care, including hygiene and bathing. Random observation on November 8, 2011, at 10:40 a.m., revealed resident #16 in the 400 hall shower room, with CNA #1 and CNA #2 in attendance. Resident #16 had just been showered and was in a shower chair, unclothed and uncovered, shivering and visibly uncomfortable, as CNA #1 dried, and prepared to dress the resident. Continued observation revealed resident #17, in a	F 241	**F 241** **Corrective action(s) accomplished for those residents found to have been affected:** Resident #16 on November 8, 2011: Certified Nursing Assistant provided a bath blanket, dried, and dressed resident. **How other residents having the potential to be affected were identified and corrective action(s) accomplished:** On November 8, 2011 Certified Nursing Assistants working the shower rooms were educated by the Assistant Director of Nursing on keeping residents covered in the shower room. **Measures or systematic changes put into place to ensure the deficient practice does not recur:** Beginning on November 9, 2011 and ongoing Certified Nursing Assistants were educated by the Director of Nursing and\or the Assistant Director of Nursing on keeping residents covered in the shower rooms. Beginning on November 9, 2011 and ongoing Licensed Nurses and Certified Nursing Assistants were educated by the Director of Nursing and/or the Assistant Director of Nursing on resident rights to include the right to dignity, privacy, and respect. In services will be added to the employee orientation packet.	11/21/2011

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F 241	Continued From page 3 wheelchair, present in the shower room, awaiting a shower, and sitting within two feet of the fully exposed resident #16. Interview with CNAs #1 and #2 confirmed that resident #16 was fully exposed, in front of resident #17, and his right to privacy and dignity, during care, had not been respected. Interview with LPN #1, the 400 hall Unit Manager, confirmed resident #16 had been unnecessarily exposed, and his privacy and dignity, during care, had not been respected.	F 241	**F 241 cont.** **Quality Assurance program put into place to monitor corrective actions and ensure the deficient practice will not recur:** Beginning on November 21, 2011, The Assistant Director of Nursing or Risk Manager will make observations of showers two times a week for four weeks to ensure residents are being provided privacy, and treated with dignity and respect the findings will be reported to the Quality Assurance Committee who will determine the need for future focus. The Assistant Director of Nursing or Risk Manger will report overall findings in the Quality Assurance Committee Meeting (which consists of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Risk Manager, etc.)	
F 257 SS=D	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to provide a comfortable temperature level for one resident (#20) of twenty-seven residents reviewed. The findings included: Resident #20 was admitted to the facility on November 5, 2009, with diagnoses including Peripheral Vascular Disease, Parkinsons, and Hypertension. Medical record review of the Minimum Data Set (MDS) dated September 14, 2011, revealed the	F 257	**F 257** **Corrective action(s) accomplished for those residents found to have been affected:** Resident #20 on November 8, 2011: Maintenance removed lock from resident's heating unit. **How other residents having the potential to be affected were identified and corrective action(s) accomplished:** On November 8, 2011 all resident rooms were checked by Maintenance for locks on heating units and any found were removed.	11/21/2011

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F 257	Continued From page 4 resident scored a fifteen on the Brief Interview for Mental Status (BIMS) and is able to make daily decisions. Observation on November 7, 2011, at 11:10 a.m., in the resident's room, revealed the resident lying on the bed dressed with a jacket on and stated, "I'm cold." Observation on November 8, 2011, at 3:10 p.m., in the resident's room, revealed the resident lying on the bed dressed with a jacket on and stated, "I'm cold and they locked my controls." Further observation revealed a key lock on the heating unit. Interview with the Maintenance Director on November 8, 2011, at 4:00p.m., in the resident's room, revealed the heat temperature set on 69 degrees and the resident had requested the temperature to be set on 74 degrees. Interview with the Nursing Home Administrator on November 8, 2011, at 4:10 p.m., in the Social Service Director office, confirmed the facility failed to provide a comfortable temperature level for the resident and the lock would be removed.	F 257	F 257 cont. **Measures or systematic changes put into place to ensure the deficient practice does not recur:** Beginning on November 8, 2011 the Maintenance Director or Maintenance Assistant will make monthly checks of resident rooms to ensure no units have had locks placed. Checks will be for six months with monthly submission to the Quality Assurance Committee who will determine the need for future focus **Quality Assurance program put into place to monitor corrective actions and ensure the deficient practice will not recur:** The Maintenance Director or Maintenance Assistant will report overall findings in the Quality Assurance Committee Meeting (which consists of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Risk Manager, etc.)	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by:	F 282		

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F 282	Continued From page 5 Based on medical record review, observation, and interview, the facility failed to implement the care plan for one (#2) of twenty-seven residents reviewed. The findings included: Resident #2 was admitted to the facility on July 8, 2011, with diagnoses including Pneumonitis, Atrial Fibrillation, Diabetes, and Chronic Obstructive Pulmonary Disease. Medical record review of the Care Plan reviewed on October 20, 2011, revealed "...Potential for skin breakdown d/t (due to) difficulty with mobility, incontinent of B&B (bowel and bladder), dx (diagnosis) of diabetes...Air mattress..." Observations on November 7, 2011, at 3:20 p.m., November 8, 2011, at 9:40 a.m., and November 9, 2011, at 9:00 a.m., revealed no air mattress was present on the resident's bed. Observation on November 9, 2011, at 9:55 a.m., with the Director of Nursing, revealed the resident lying on the bed. Continued observation revealed a skin assessment was completed and there were no areas of skin breakdown. Interview on November 9, 2011, at 9:55 a.m., with the Director of Nursing, in the resident's room, confirmed the air mattress was not applied to the resident's bed.	F 282	**F 282** **Corrective action(s) accomplished for those residents found to have been affected:** Resident #2 on November 09, 2011 had air mattress applied to bed by the central supply clerk. **How other residents having the potential to be affected were identified and corrective action(s) accomplished:** On November 16, 2011 the wound care nurse checked all residents with an order for an air mattress to ensure mattress was in place. **Measures or systematic changes put into place to ensure the deficient practice does not recur:** Beginning on November 16, 2011; the wound care nurse or Risk Manager will make random checks of residents with orders for air mattresses once a month and when a new order is received for one year with monthly submission to the Quality Assurance committee who will determine the need for future focus. **Quality Assurance program put into place to monitor corrective actions and ensure the deficient practice will not recur:** The Director of Nursing or the Risk Manager will report the overall findings in the Quality Assurance Committee Meeting (which consists of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Risk Manager, etc.)	11/21/2011
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a	F 315		

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F 315	Continued From page 6 resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to complete a bladder assessment and develop a bladder retraining program for one (#2) of twenty-seven residents reviewed. The findings included: Resident #2 was admitted to the facility on July 8, 2011, with diagnoses including Pneumonitis, Atrial Fibrillation, Diabetes, and Chronic Obstructive Pulmonary Disease. Medical record review of the Minimum Data Sets dated July 17, 2011, and October 12, 2011, revealed the resident was incontinent of bladder. Medical record review of an undated and unsigned Bladder Incontinence Evaluation revealed the resident was alert, followed directions, and had daily incontinent episodes with some control. Continued review of the Bladder Incontinence Evaluation revealed the section for Evaluation for Bladder Program Potential had not been completed.	F 315	F 315 **Corrective action(s) accomplished for those residents found to have been affected:** Resident #2 on November 08, 2011; L.P.N completed a bowel and bladder assessment and started a B&B plan. **How other residents having the potential to be affected were identified and corrective action(s) accomplished:** On November 14, 2011 the Unit Managers began checking all resident's charts to ensure bowel and bladder assessments were complete and plans started per policy. All chart checks will be completed by November 21, 2011. **Measures or systematic changes put into place to ensure the deficient practice does not recur:** Beginning on November 14, 2011 the Unit Managers or Risk Manager will make random checks of bowel and bladder assessments to ensure completion and plans have been started per policy. The checks will be done two times a month for six months with monthly submission to the Quality Assurance Committee who will determine the need for future focus. **Quality Assurance program put into place to monitor corrective actions and ensure the deficient practice will not recur:** The Director of Nursing or the Risk Manager will report overall findings in the Quality Assurance Committee Meeting (which consists of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Risk Manager, etc.)	11/21/2011

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F 315	Continued From page 7 Medical record review revealed no documentation a bladder retraining program had been established for the resident. Interview on November 9, 2011, at 9:30 a.m., with the resident, in the resident's room, revealed the resident had the perception of the need to void. Interview on November 8, 2011, at 11:00 a.m., with Licensed Practical Nurse #2, in the conference room, confirmed the undated and unsigned Bladder Incontinence Evaluation was not complete and confirmed a bladder retraining program had not been established for the resident.	F 315	F 323 **Corrective action(s) accomplished for those residents found to have been affected:** Resident #1 on November 9, 2011; Restorative aid checked bed alarm, alarm working and mats were placed correctly at the bedside by Restorative aid. Resident #23 on November 15, 2011; LPN obtained physician's order for mats at bedside while in bed except when eating. Resident #12 on November 8, 2011; seatbelt was checked immediately by the Assistant Director of Nursing and functioning correctly.	11/21/2011
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of the manufacturer's recommendations, observation, and interview, the facility failed to ensure safety devices were in place and functioning for five (#1, #23, #12, #22, #14) residents, failed to provide supervison to prevent an accident for one (#14) resident, failed to implement new interventions after three falls for one (#3) resident, and failed to ensure restraints were applied correctly for two	F 323	Resident #22 on November 9, 2011; Restorative aid placed mats at bedside also pressure pad alarm cord was replaced and in working order. Resident #3 on November 7, 2011; Certified Nursing Assistant removed soft waist restraint and applied correctly. Resident #14 on November 7, 2011; Certified Nursing Assistant removed soft waist restraint and applied correctly. On November 16, 2011; Resident's kardex was updated by Licensed Practical Nurse to reflect not to leave resident unattended in restroom. **How other residents having the potential to be affected were identified and corrective action(s) accomplished:** On November 15, 2011 Restorative nurse aid checked all residents with safety devices to ensure correct placement.	

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F 323	Continued From page 8 (#3, #14) residents of twenty-seven residents reviewed. The findings included: Resident # 1 was readmitted to the facility on October 5, 2011, with diagnoses including Fracture Lower End Femur, Hypertension, Chronic Obstructive Pulmonary Disease, Osteoarthritis, Osteopenia, and Alzheimer's Disease. Medical record review of the Minimum Data Set (MDS), dated October 13, 2011, revealed the resident had severely impaired cognitive skills, was totally dependent with transfers. Further review of the MDS revealed the resident had a history of two falls. Medical review of the nurse's notes, dated October 5, 2011, revealed "...observed resident on floor next to bed lying on back, c/o (complaint of) neck and back pain at 10:20 p.m. (October 4, 2011)...sent to ER (Emergency Room) to be evaluated..." Review of facility documentation dated October 4, 2011; revealed "...observed resident on floor next to bed...resident tried to get out of bed...bedrails to HOB (head of bed) ½ up...bed alarm...bed alarm was not positioned under resident properly..." Review of resident #1's care plan, dated October 10, 2011, revealed "...bed alarm as ordered...mat to exit side of bed...bed in lowest position..." Observation on November 7, 2011, at 11:30 a.m.,	F 323	F 323 cont. **Measures or systematic changes put into place to ensure the deficient practice does not recur:** Beginning on November 07, 2011 and ongoing Licensed Nurses and Certified Nursing Assistants were educated by the Director of Nursing and/or the Assistant Director of Nursing on proper soft waist placement with return demonstration. Beginning on November 08, 2011 and ongoing Licensed Nurses and Certified Nursing Assistants were educated by the Director of Nursing and/or the Assistant Director of Nursing on not leaving residents alone in the restroom that need extensive assistance. In services will be added to the employee orientation packet. **Quality Assurance program put into place to monitor corrective actions and ensure the deficient practice will not recur:** Beginning on November 15, 2011, the restorative aid or designee as determined by the Director of Nursing will make random checks of safety measures to ensure correctness and placement. The checks will be done two times a week for ninety days with monthly submission to the Quality Assurance Committee who will determine the need for future focus. The Director of Nursing or the Assistant Director of Nursing will report the overall findings in the Quality Assurance Committee Meeting (which consists of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Risk Manager, etc.)	11/21/2011

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F 323	Continued From page 9 3:15 p.m., November 8, 2011, at 9:30 a.m. and 2:00 p.m., in the resident's room, revealed the resident lying on the bed and mats were not in place to the exit side of bed. Interview with the Assistant Director of Nursing (ADON), on November 9, 2011, at 9:00 a.m., in the 100 Wing hallway nurses station, confirmed the bed alarm was not functioning on October 4, 2011, when the resident was found lying in the floor. Interview with RN #2, on November 9, 2011, at 10:20 a.m., in the Risk Manager's office, confirmed the bed alarm was not positioned properly and the alarm did not sound when the resident was found lying in the floor on October 4, 2011. Interview with Licensed Practical Nurse (LPN) #3, on November 19, 2011, at 10:50 a.m., in the 100 Wing Nurses Station, confirmed the facility failed to place the floor mats to the exit side of the bed on October 4, 2011, and the mat is not in place at this time. Resident #23 was readmitted to the facility on April 12, 2011, with diagnoses including Dysphasia, Diabetes, Hypertension, Atrial Fibrillation, Amputation below the Right Knee, and Peripheral Vascular Disease. Medical review of the Minimum Data Set (MDS), dated September 30, 2011, revealed the resident had no short or long term memory deficits and required assistance with transfers. Medical record review of Progress notes dated	F 323		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 10 September 25, 2011, and October 18, 2011, revealed the resident had "...slid out of bed with no injuries..." Medical record review of a nurse's note dated October 18, 2011, revealed "...CNA (certified nurse assistant) notified charge nurse resident was in floor...nurse observed resident on floor next to bed...c/o (complaint of) no pain and no s/o (sign of) injuries..." Review of the resident's Care Plan, last dated September 3, 2011, revealed "...blue mats at bedside..." Review of facility documentation, dated October 19, 2011, revealed "...interventions: high low bed, ½ side rails to HOB (head of bed), blue mats at bedside..." Observation on November 8, 2011, at 2:50 p.m., revealed the resident lying in the bed, both side rails up, and the blue mats at the head of the bed, not positioned on the floor. Interview and observation with Certified Nurse Assistant (CNA) #9, on November 8, 2011, at 4:00 p.m., in the 100 Wing hallway, confirmed the mats were behind the head of the bed and not positioned on the floor. Interview with Registered Nurse (RN) #2, on November 9, 2011, at 10:30 a.m., in the Risk Manager's office, confirmed the facility had failed to place the blue floor mats at the resident's bedside while in the bed. Resident #12 was admitted to the facility on	F 323		

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	445174	A. BUILDING _____ B. WING _____	11/09/2011

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F 323	Continued From page 11 December 23, 2009, with diagnoses including Mental Disorder, Hypertension, and Osteoporosis. Medical record review of the physician's recapitulation orders dated March, 2011, revealed "...Alarming Seat Belt in W/C (wheelchair)..." Medical record review of the Interdisciplinary Post-Fall Assessment dated March 28, 2011, revealed the resident had a history of falls. Medical record review of a Nurse's Note dated March 28, 2011, revealed, "...staff observed resident laying on floor on (left) side in front of bathroom door...(no) injuries...upon inspection of seat belt alarm, we discovered it had never alarmed when resident got up from w/c because it wasn't powered on. Seat belt placed on resident properly, and powered on..." Interview on November 8, 2011, at 8:50 a.m., with the Director of Nursing, in the conference room, confirmed the safety device was not functioning at the time of the fall on March 28, 2011. Resident #22 was admitted to the facility on February 17, 2011, with diagnoses including Fractured Neck of Femur, Diabetes, and Psychosis. Medical record review of a fall risk assessment dated August 30, 2011, revealed the resident was at high risk for falls. Medical record review of the current care plan dated August 18, 2011, revealed " ...Bed alarm...mat to exit side of bed while pt (patient) in	F 323		

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F 323	Continued From page 12 bed..." Observation and interview with RN (Registered Nurse) #1 on November 9, 2011, at 8:35 a.m., revealed the resident lying on the bed without a mat to the exit side of the bed, and the pressure pad alarm cord unhooked lying on the floor. Resident #3 was admitted to the facility on May 24, 2011, with diagnoses including Alzheimer Disease, History of Falls, and Fracture of Ribs. Medical record review of the Minimum Data Set (MDS) dated August 23, 2011, revealed the resident required extensive assistance with transfers. Medical record review of the Care Plan dated September 1, 2011, revealed the resident was at risk for falls, the resident was on the Falling Star program, and a soft waist restraint was to be used when up in the wheelchair. Medical record review of the Physician's recapitulation Orders dated November 2011, revealed "...Soft Waist Restraint in W/C...Falling Star program." Review of the Falling Star program revealed "...after a fall...a new intervention must be provided immediately to assure resident safety..." Medical record review of facility documentation dated October 4, 2011, at 2:00 a.m., revealed "...observed resident laying in floor next to bed...", October 8, 2011, at 9:20 a.m., "...observed resident sitting in floor in front of closet...", and October 8, 2011, at 8:00 p.m., "...observed sitting	F 323		

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F 323	Continued From page 13 on bottom in floor beside bed in front of W/C..." Interview with Registered Nurse #2 on November 8, 2011, at 3:20 p.m., at the 400 Nurses' Station, confirmed no new interventions had been put in place after the falls and the Falling Star program had not been followed. Observation on November 7, 2011, at 3:15 p.m., in the resident's room, revealed the resident in a wheelchair with a soft waist restraint. Continued observation revealed the left strap of the belt was between the wheelchair seat and the wheelchair skirt guard and the right strap of the belt was placed over the wheelchair skirt guard. Review of the manufacturer's application instruction sheet for the lap belt revealed "...lay the belt across the patient's lap...bring the strap ends with loops down over the thighs between the seat and the wheelchair skirt guard...go around the back post and cross the straps behind the patient...secure the loops on the wheelchair tilt levers...belt should be over the patient's hips at a 45-degree angle holding the hips against the back of the chair..." Interview with Registered Nurse #1 on November 7, 2011, at 3:15 p.m., in the resident's room, confirmed the soft waist restraint was not applied correctly according to the manufacturer's instructions. Resident #14 was admitted to the facility on July 20, 2010, with diagnoses including Femur Fracture, History of Falls, and Difficulty Walking. Medical record review of the Minimum Data Set	F 323		

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F 323	Continued From page 14 (MDS) dated September 13, 2011, revealed the resident had severely impaired cognitive skills, not steady moving on and off toilet, totally dependent for toilet use, required extensive assistance with transfers, and did not walk. Medical record review of the Care Plan dated September 22, 2011, revealed "...soft waist restraint to be used while in wheelchair...Falling Star program...Bed Alarm as ordered..." Medical record review of the Physician's Orders dated November 2011, revealed "...Soft Waist Restraint in W/C...Falling Star program...Bed Alarm to alert staff of unassisted transfers..." Medical record review of Nurse's Notes dated April 4, 2011, at 6:30 p.m., revealed "...observed resident sitting in floor on buttocks in front of wheelchair...alarm from seat belt never alarmed...checked alarm observed to be in off position..." Medical record review of Nurse's Notes dated August 19, 2011, at 1:35 p.m., revealed "...resident observed sitting in floor after going to bathroom..." Interview with the Director of Nursing (DON) on November 8, 2011, at 8:40 a.m., in the 400 Nurses' Station, confirmed the resident's alarm was not in the on position on April 4, 2011, and all alarms are to be on at all times, and the resident was left unattended on the commode on August 19, 2011, and the resident required extensive assist with toileting and should not be left unattended on the commode.	F 323		

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F 323	Continued From page 15 Observation on November 7, 2011, at 4:00 p.m., in front of the 400 Nurses' Station, revealed the resident in a wheelchair with a soft waist restraint. Continued observation revealed the straps on the belts were under the axle of the wheel of the wheelchair and looped over the wheelchair tilt levers. Interview with Registered Nurse #1 on November 7, 2011, at 4:00 p.m., in front of the 400 Nurses' Station, confirmed the soft waist restraint was not applied correctly according to the manufacturer's instructions.	F 323	F 332 **Corrective action(s) accomplished for those residents found to have been affected:** Resident #19 on November 7, 2011; Licensed Practical Nurse corrected insulin dose and the correct dose administrated. Resident #19 on November 7, 2011; Licensed Practical Nurse notified Nurse Practitioner and no adverse reactions noted. Resident #18 on November 7, 2011; Licensed Practical Nurse notified Nurse Practitioner and no adverse reactions noted.	11/21/2011
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, medical record review, review of manufacturer's instructions, and interview, the facility failed to appropriately administer medications in three of forty-one opportunities, resulting in a 7.3% medication error rate. The findings included: Observation on November 7, 2011, at 4:45 p.m., revealed Licensed Practical Nurse (LPN) #3 performed an accucheck (test to monitor blood sugar) to resident #19. Continued observation revealed the resident's blood sugar registered 366.	F 332	**How other residents having the potential to be affected were identified and corrective action(s) accomplished:** Beginning on November 8, 2011 and ongoing the Licensed Nurses were educated by the Director of Nursing and/or the Assistant Director of Nursing on the correct wait times between inhalers. Beginning on November 8, 2011 and ongoing the nurses were educated by the Director of Nursing and/or the Assistant Director of Nursing on correct charting of a blood glucose levels and verifying the units of insulin with a second nurse. Beginning on November 8, 2011 and ongoing the nurses were also educated by the Director of Nursing and/or the Assistant Director of Nursing on verifying correct dosage of medication before administering. In services will be added to the Licensed Nurses orientation packet.	

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F 332	Continued From page 16 Medical record review of the November 2011, physician's recapitulation orders revealed "...Accuchecks BID (twice a day) with Standard...Sliding Scale Insulin as follows: Novolin R insulin...351-400=12u (units)..." Continued observation revealed LPN #3 prepared an injection of Novolin R insulin. Observation and interview with LPN #3 revealed LPN #3 stated had prepared 12 units of the Novolin R insulin. Continued observation revealed the insulin syringe contained 14 units of Novolin R insulin. Continued observation revealed LPN #3 entered the resident's room to administer the insulin, and was asked to observe the amount of insulin in the syringe and expelled 2 units of insulin from the syringe. Interview on November 7, 2011, at 4:50 p.m., with LPN #3, in the resident's room confirmed the amount of insulin prepared to administer to the resident was not correct. Observation on November 7, 2011, at 4:57 p.m., revealed LPN #3 administered Acetaminophen (pain medication) 650 mg (milligrams) to resident #19. Medical record review of the November 2011, physician's recapitulation orders revealed the resident was to receive Acetaminophen 500 mg every eight hours. Interview on November 7, 2011, at 5:10 p.m., with LPN #3, in the hallway confirmed the resident did not receive the correct dosage of the Acetaminophen.	F 332	**F 332 Cont.** **Measures or systematic changes put into place to ensure the deficient practice does not recur:** Beginning on November 21, 2011; the Risk Manager or Assistant Director of Nursing will do random observations of med passes to ensure correct medication and dose are being given. The checks will be done twice a week for ninety days with monthly submission to the Quality Assurance Committee who will determine the need for future focus. **Quality Assurance program put into place to monitor corrective actions and ensure the deficient practice will not recur:** The Risk Manager or the Assistant Director of Nursing will report overall findings in the Quality Assurance Committee Meeting (which consists of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Risk Manager, etc.)	

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F 332	Continued From page 17 Observation on November 8, 2011, at 8:39 a.m., revealed LPN #4 administering medications to resident #18. Continued observation revealed LPN #4 administered an inhalation of Combivent (bronchodilator aerosol), waited 25 seconds and administered the second inhalation of Combivent. Review of the manufacturer's instructions for Combivent revealed approximately two minutes were to elapse between inhalations. Interview on November 8, 2011, at 9:15 a.m., with LPN #4, at the nursing station, confirmed LPN #4 did not wait two minutes between the inhalations of Combivent.	F 332	F 371 **Corrective action(s) accomplished for those residents found to have been affected:** No residents were identified. **How other residents having the potential to be affected were identified and corrective action(s) accomplished:** On November 8, 2011; the Dietary Manager made a check of the kitchen to ensure the proper scoop sizes was being used, the hand washing policy was being followed, and food was being stored properly. **Measures or systematic changes put into place to ensure the deficient practice does not recur:**	11/21/2011
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policies, review of the dietary menus, and interview, the facility failed to ensure food was stored properly, failed to ensure proper hand hygiene was followed, failed to prevent ice buildup in the walk in freezer, and failed to ensure the proper scoop	F 371	Beginning on November 10, 2011 the kitchen staff was educated by the Director of Dietary on the proper scoop size, the hand washing policy, and the proper storage of food. In service will be added to the dietary employee orientation packet. **Quality Assurance program put into place to monitor corrective actions and ensure the deficient practice will not recur:** Beginning on November 8, 2011; the Dietary Manager or Dietary Assistant will do random checks of the kitchen to ensure proper kitchen procedures are being followed. The checks will be twice a month for twelve months with monthly submission to the Quality Assurance Committee who will determine the need for future focus. The Director of Dietary or Dietary Assistant will report overall findings in the Quality Assurance Committee Meeting (which consists of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Risk Manager, etc.)	

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F 371	Continued From page 18 sizes were used in serving food in dietary. The findings included: Observation and interview on November 7, 2011, at 11:15 a.m., with the Dietary Manager, in the dietary department revealed the following: approximately one and half inch build up of ice on the floor in the walk in freezer; 1 box southern style okra, unopened; 1 box vanilla mighty shakes, unopened; 1 box vanilla pudding, unopened; 1 box boneless skinless chicken breast, unopened; 2 boxes sweet potatoes, unopened; 2 boxes breaded fish nuggets, unopened, sitting on the floor in the walk in freezer. Observation on November 7, 2011, at 11:20 a.m., revealed Dietary Staff #1, entered dietary from an outside door, opened and closed the door to the dining room, went over to a table in dietary and picked up sandwiches covered in plastic wrap without washing the hands. Review of the facility policy, Nutritional Services Infection Control and prevention of Contamination, revealed, "...Do not store food on the floor..." Interview on November 7, 2011, at 11:25 a.m., with the Dietary Manager, confirmed hands are to be washed prior to handling food. Review of the Spreadsheet of Diets, revealed "...Chicken & Dumplings (8 oz)...Carrots (1/2 cup)..." Observation on November 7, 2011, at 11:45 a.m.,	F 371		

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F 371	Continued From page 19 in the dietary department, with the Dietary Manager, revealed the dietary staff #2 served chicken and dumplings using a 4 ounce scoop, and served carrots using a 2 ounce scoop during the lunch meal. Interview on November 8, 2011, at 10:00 a.m., with the Dietary Manager, in the conference room, confirmed the proper scoop size for the chicken and dumplings was an 8 ounce scoop and the proper scoop size for the carrots was a 4 ounce scoop and the incorrect scoop sizes had been used in serving the chicken and dumplings and carrots.	F 371	F 386 **Corrective action(s) accomplished for those residents found to have been affected:** Resident #17 on November 8, 2011; Nurse Practitioner signed September and October physician orders. **How other residents having the potential to be affected were identified and corrective action(s) accomplished:** Beginning on November 14, 2011; Physicians are being educated by the Medical Records Director on the importance of signing orders timely.	11/21/2011
F 386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on medical record review, facility policy review, and interview the facility failed to ensure two physician's orders were signed timely for one resident (#17) of twenty-seven residents reviewed. The findings included:	F 386	**Measures or systematic changes put into place to ensure the deficient practice does not recur:** Beginning on November 21, 2011 the Medical Records Director or the Assistant Director of Nursing will do random checks of physician orders to ensure orders are being signed timely. The checks will be done once a month for six months with monthly submission to the Quality Assurance Committee who will determine the need for further focus. **Quality Assurance program put into place to monitor corrective actions and ensure the deficient practice will not recur:** The Director of Nursing or the Assistant Director of Nursing will report overall findings in the Quality Assurance Committee Meeting (which consists of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Risk Manager, etc.)	

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F 386	Continued From page 20 Resident #17 was admitted to the facility on June 11, 2011, with diagnoses including Hypertension, Osteoarthritis, and Congestive Heart Failure. Medical record review of the physician's recapitulation orders for September 2011 and October 2011, revealed the physician's orders were unsigned and undated by the treating physician. Continued medical record review revealed two telephone orders, dated September 14, 2011, and October 5, 2011, had been signed by the physician. Review of the facility policy, Physician Services, revealed "...Physician services include, but are not limited to: ...3. d. Written and signed orders for diet, care, and diagnostic tests and health-related treatment of residents ... " Interview with the ADON (Assistant Director of Nursing), on October 8, 2011, at 2:35 p.m., at the 400 hall nursing station, confirmed that resident #17's recapitulation orders had been flagged for the physician to sign, but to date, neither September 2011, nor October 2011, recapitulation orders had been signed and dated timely, by the prescribing physician.	F 386		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control	F 441		

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F 441	Continued From page 21 Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, and interview, the facility failed to maintain infection control measures during ice pass on the one hundred hallway for four residents. The findings included:	F 441	F 441 **Corrective action(s) accomplished for those residents found to have been affected:** The Geri-tech on November 8, 2011 was given hand sanitizer by the Assistant Director of Nursing to have on her person and educated on the hand washing policy and use of hand sanitizer. **How other residents having the potential to be affected were identified and corrective action(s) accomplished:** Beginning on November 09, 2011 and ongoing the nursing staff was educated by the Director of Nursing and/or the Assistant Director of Nursing on the hand washing policy and the use of hand sanitizer. In service will be added to the employee orientation packet. **Measures or systematic changes put into place to ensure the deficient practice does not recur:** Beginning on November 21, 2011 the Risk Manager or the Assistant Director of Nursing will make random checks of ice passes to ensure that the hand washing policy is being followed. The checks will be done twice a month for six months with monthly submission to the Quality Assurance Committee who will determine the need for future focus. **Quality Assurance program put into place to monitor corrective actions and ensure the deficient practice will not recur:** The Director of Nursing or Assistant Director of Nursing will report overall findings in the Quality Assurance Committee Meeting (which consists of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Risk Manager, etc.)	11/21/2011

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKHAVEN MANOR	2035 STONEBROOK PLACE KINGSPORT, TN 37660

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 22 Observation on November 8, 2011, at 9:00 a.m., on the 100 hallway, revealed the Geri-Tech (nursing aide assistant), filling ice water pitchers for four residents. Continued observation revealed the technician went into each room, brought the ice pitchers outside the room, filled the pitchers with ice, returned the pitchers into the room, and exited without sanitizing the hands between residents. Review of facility policy, Handwashing/Hand Hygiene, dated September 2005, revealed "...all personnel shall follow the hand-washing/hand hygiene procedures to help prevent the spread of infection to other personnel, residents and visitors...use of Alcohol-Based Hand Rub containing 60-95% ethanol or isopropanol...after contact with objects in the immediate vicinity of the resident..." Interview with the Geri-Tech, on November 8, 2011, at 9:05 a.m., in the 100 Wing hallway, confirmed the Geri-Tech had not sanitized the hands between residents. Interview with the Assistant Director of Nursing (ADON), on November 8, 2011, at 9:15 a.m., in the 100 Wing hallway confirmed the Geri-Tech failed to follow standard infection control practice by not sanitizing the hands between residents.	F 441	F 465 **Corrective action(s) accomplished for those residents found to have been affected:** No residents were identified. **How other residents having the potential to be affected were identified and corrective action(s) accomplished:** On November 9, 2011 a check of all resident restroom was completed by the Director of Maintenance and the Maintenance Assistant and a list complied of needed repairs. A vendor was retained to address the immediate concerns related to grouting of all commodes identified on the POC. Those requiring more extensive repair whereby tile replacement is required will be completed by December 20, 2011 to allow for ordering and proper installation. **Measures or systematic changes put into place to ensure the deficient practice does not recur:** Beginning on November 9, 2011 the Maintenance Director will make monthly inspections of resident restrooms to address needed repairs. The inspections will be done monthly for three months then quarterly thereafter with submission to the Quality Assurance Committee.	12/20/11
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F 465	**Quality Assurance program put into place to monitor corrective actions and ensure the deficient practice will not recur:** The Maintenance Director or the Maintenance Assistant will report the overall findings in the Quality Assurance Committee Meeting (which consists of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Risk Manager, etc.)	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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BROOKHAVEN MANOR	2035 STONEBROOK PLACE KINGSPORT, TN 37660

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F 465	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide a safe and sanitary environment for thirty-four resident bathrooms observed. The findings included: Observation of thirty-four resident bathrooms on November 7-9, 2011, revealed the following: floor tiles cracked and missing; the door frames rusty and paint missing; toilet paper rolls missing; holes in the walls; the base of the commodes were brown with caulk missing, and baseboards were loose and in need of repair Observation and interview with the Maintenance Director on November 9, 2011, at 8:30 a.m., in the resident bathrooms, confirmed the bathrooms had not been maintained in a safe and sanitary manner and were in need of repair.	F 465	**F 490** **Corrective action(s) accomplished for those residents found to have been affected:** All residents had the potential to be affected. On November 7, 2011 the fire watch policy was implemented immediately by the Director of Maintenance. **How other residents having the potential to be affected were identified and corrective action(s) accomplished:** Beginning on November 7, 2011 the fire watch policy will stay in effect until the new sprinkler system is inspected and the Department allows us to lift the watch. On November 18, 2011 the Assistant City of Kingsport Fire Marshall inspected the new system. Also training was done with the Kingsport Fire Department on the new system.	11/21/2011
F 490 SS=L	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to be administered in a manner to maintain the safety of residents by failure to ensure the fire sprinkler system was in	F 490	On November 18, 2011 at approximately 1:15 pm per a phone conversation with State Fire Inspector fire watch was lifted for the building. **Measures or systematic changes put into place to ensure the deficient practice does not recur:** The old sprinkler system is being replaced with a new system. As of November 17, 2011 the new system is fully functional and being monitored. We are just waiting on our final inspection from the State. As of November 18, 2011 any reports on the sprinkler system will be given to the Administrator for signature.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKHAVEN MANOR	2036 STONEBROOK PLACE KINGSPORT, TN 37660

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F 490	Continued From page 24 reliable operating condition. The facility's failure placed all 161 residents in the facility in immediate Jeopardy from the likelihood of burns, smoke inhalation, and death should an undetected fire occur. The Administrator was informed of the Immediate Jeopardy on November 7, 2011, at 4:02 p.m. Refer to Life Safety Code K-62, related to failing to maintain the fire sprinkler system in reliable operation. Refer to Life Safety Code K-154, related to evacuating the building or providing an approved fire watch if the fire sprinkler system is out of service. A fire watch was implemented immediately on the evening of November 7, 2011, removing the immediacy of the jeopardy. An Allegation of Compliance was accepted November 8, 2011, lowering the scope and severity of the deficient practice to an F level.	F 490	F 490 cont. **Quality Assurance program put into place to monitor corrective actions and ensure the deficient practice will not recur:** As of November 17, 2011 the new system will be put on a regular maintenance program to keep it in operation with current regulations. The Maintenance Director or the Maintenance Assistant will report any issues to the Quality Assurance Committee (which consists of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Risk Manager, etc.) on a ongoing basis.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State;	F 514		

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F 514	Continued From page 25 and progress notes. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to maintain accurate medication administration records for one resident (#8) of twenty-seven residents reviewed. The findings included: Medical record review of the Medication Administration Record (MAR) dated November 2011, revealed "...Metolazone (Zaroxolyn) 2.5 mg po (by mouth) q day (daily), Edema **HOLD if SBP (systolic blood pressure) > (over) 90**..." Further medical record review of the signed Physician Orders dated July 2011, August 2011, September 2011, October 2011, and November 2011, revealed "...Metolazone (Zaroxolyn) 2.5mg po q day **HOLD if SBP > 90**. Interview with the Assistant Director of Nursing (ADON), in the nursing office on November 8, 2011, at 9:40 a.m., confirmed the parameter to hold the metolazone, a diuretic, when systolic blood pressure was "over" 90 was a typographical error, and should have stated "less than" or "<" and should have been corrected by nursing audits of the Physician Orders and MARs.	F 514	F 514 **Corrective action(s) accomplished for those residents found to have been affected:** Resident #8 on November 8, 2011; Licensed Practical Nurse corrected MAR and Nurse practitioner was notified. **How other residents having the potential to be affected were identified and corrective action(s) accomplished:** On November 09, 2011 the Medical Records Director was educated by the Director of Nursing on ensuring correctness of physician orders before transcribing orders onto the medication administration record. **Measures or systematic changes put into place to ensure the deficient practice does not recur:** Beginning on November 21, 2011 the Risk Manager or the Assistant Director of Nursing will make random checks of medication administration records to ensure orders are transcribed correctly. The checks will be done two times a week for ninety days with monthly submission to the Quality Assurance Committee who will determine the need for future focus. **Quality Assurance program put into place to monitor corrective actions and ensure the deficient practice will not recur:** The Director of Nursing or the Assistant Director of Nursing will report overall findings in the Quality Assurance Committee Meeting (which consists of the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Risk Manager, etc.)	11/21/2011